No. 95-1594

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

BARBARA A. DE BUONO, M.D., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE, in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

—against—

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR PETITIONERS

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QUESTION PRESENTED

Whether section 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144(a) (1994), preempts New York Public Health Law § 2807-d (McKinney 1993), which imposes a tax of six-tenths of one percent on the operating income of all hospitals in New York State, to the extent that the tax is applied to the income of medical centers owned and operated by an ERISA fund.

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BRIEF FOR PETITIONERS

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Second Circuit is reported at 74 F.3d 28 (2d Cir. 1996) and

reproduced at JA 6.[1] The order of the Supreme Court granting a writ of certiorari, vacating the judgment and remanding the case to the Second Circuit is reported at 115 S. Ct. 1819 (1995) and is reproduced at 5a. The initial opinion of the Second Circuit is reported at 27 F.3d 823 (2d Cir. 1994) and is reproduced at JA 10. The memorandum opinion and order of the United States District Court for the Southern District of New York (Martin, J.) is not reported and is reproduced at 15a to 23a.

JURISDICTION

This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1) (1994). The judgment of the court of appeals was entered on January 4, 1996. A petition for a writ of certiorari was timely filed on April 3, 1996.

STATUTES INVOLVED

The pertinent statutes, section 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144(a) and N.Y. Pub. Health Law §§ 2801(1), 2807-d(1)(a), 2807-d(2)(c) (McKinney 1993), are reproduced in the appendix to the petition for a writ of certiorari at 27a to 28a.

STATEMENT OF THE CASE

This case questions the extent to which ERISA preemption insulates ERISA-covered welfare benefit plans from traditional areas of state regulation when plans choose to operate in those areas. New York regulates all providers of hospital care services without regard to whether a provider is owned

[1] References to the joint appendix filed with this Court are cited as (JA ___). References to the appendix attached to the petition for writ of certiorari are cited as (_a).

by an ERISA plan. If a plan chooses to operate its own medical center, instead of purchasing services from others, the State's regulation falls upon plan-owned facilities.

In this case, the ERISA plan has argued, and the Second Circuit has agreed, that a generally applicable tax imposed upon all hospitals in New York cannot be imposed on plan-owned facilities simply because they are plan-owned. States must be able to regulate the activities in which ERISA plans choose to engage so long as that regulation does not impermissibly intrude upon those plan functions which ERISA preemption is intended to protect, that is, plan administration and plan benefit structure. Any other result would confer upon ERISA plans a charmed existence which Congress did not intend.

A. The Hospital Assessment

In 1990, in order to offset increased health care costs and as an alternative to substantial Medicaid payment reductions which would otherwise have been required (JA 42-43, 50), the New York State Legislature enacted section 2807-d of the New York Public Health Law, referred to by the courts below as the Health Facility Assessment or "HFA." 1990 N.Y. Laws, ch. 938.[2] The HFA, with certain exceptions not relevant here, is imposed upon all "hospitals" in New York. Hospitals are defined to encompass any facility engaged in providing services under the supervision of a physician or dentist, including diagnostic centers and treatment centers. N.Y. Pub. Health Law § 2801(1) (McKinney 1993).

The HFA is assessed at six-tenths of one percent for diagnostic and treatment centers. Assessable income is defined to include all gross receipts from: (1) patient care services irrespective of payment source; (2) investment income; and (3)

[2] The assessment, as originally enacted, was to expire on April 1, 1992, but was amended to remain in effect after that date. 1995 N.Y. Laws, ch. 2, § 135.

other operating income, such as non-patient food sales, parking revenues, medical records fees, and the like (JA 60-61). N.Y. Pub. Health Law §§ 2807-d(1)(a), 2807-d(2)(c) (McKinney 1993). Hospitals are required to submit quarterly reports of gross receipts subject to the tax. N.Y. Pub. Health Law § 2807-d(7)(d) (McKinney 1993). Assessments are to be forwarded monthly and eventually become part of the State's general fund (JA 48-49).

Respondents are trustees of the NYSA-ILA Medical and Clinical Services Fund (the "Fund"). The Fund is a labor-management trust governed by Section 302 of the Labor-Management Relations Act of 1947, 29 U.S.C. § 186. It was established pursuant to collective bargaining agreements between the New York Shipping Association, Inc. ("NYSA") and the International Longshoremen's Association ("ILA") (JA 20-21). The Fund administers a self-insured, ERISA covered, multi-employer welfare benefit plan ("NYSA plan"). *See* 29 U.S.C. § 1002 (1).

The Fund owns and operates two medical centers in New York and one in New Jersey which deliver medical, dental, and other health care services on an outpatient basis (JA 21). The New York medical centers are incorporated separately as New York not-for-profit corporations and are licensed by the New York State Department of Health as "diagnostic and treatment centers" pursuant to N.Y. Pub. Health Law § 2805 (McKinney 1993)(JA 98). The centers deliver medical services principally to NYSA employed longshore workers, retirees, and dependents (JA 75-76). The centers also deliver medical services to ILA members employed by non-longshore employers ("outside employers") (JA 76). Finally, the centers deliver medical services to members of another union, the Port Police and Guards Union ("PPGU"), pursuant to a contract between the PPGU's ERISA plan and the Fund (JA 75-76, 78).

The medical centers' income is derived from a number of sources. NYSA employer contributions are remitted to the Fund which in turn transfers them to the medical centers as needed. Outside employer contributions are remitted directly to the medical centers. Fee-for-service payments are made directly to the medical centers by the PPGU fund and from workers' compensation carriers. Employee registration fees and co-payments for services are made to the centers. Finally, there are miscellaneous sources, such as supplier rebates and medical records fees (JA 77-79, 81-82).

The medical centers filed reports and paid the hospital assessment for the period from January 1, 1991 through November 30, 1991 (JA 81-82, 84-96). The centers did not report as assessable income any monies transferred from the Fund, treating such income as a grant which is non-assessable income under state law (JA 80-81). The State did not contest that exclusion. The centers reported as assessable income outside employer contributions to the centers, fee-for-service payments from the PPGU fund and workers' compensation carriers, employee payments for certain services, as well as miscellaneous income (JA 80-81). For the period January 1, 1991 through November 30, 1991, the centers reported assessable income of $1,177,670 and paid assessments totaling $7,066.02 (JA 81-82). Thereafter, the centers discontinued filing reports and paid no further assessments (JA 82).

B. Prior Proceedings

On April 16, 1992, the Fund commenced this action against the New York State Commissioner of Health and other Health Department officials (referred to collectively as the "State") for declaratory and injunctive relief and for a refund of the assessments already paid on the ground that the hospital assessment is preempted by ERISA to the extent it "imposes a levy on contributions and payments for health care benefits provided by the Fund" (9a). The parties cross-moved for summary judgment pursuant to Fed. R. Civ. P. 56.

In an opinion dated February 18, 1993, the district court granted the State's motion, determining that the hospital assessment is not preempted by ERISA. The court reasoned that the HFA is a law of general application applying to all health facilities with only an incidental economic impact on ERISA plans (21a).[3] The court concluded that the tax "does not interfere with calculation of benefits" or with the "determination of an employee's eligibility for benefits" (21a). Pointing to the *de minimis* amount of the assessment, the court distinguished this case from *The Travelers Insurance Co. v. Cuomo*, 813 F. Supp. 996 (S.D.N.Y.), *aff'd*, 14 F.3d 708 (2d Cir. 1993), *rev'd sub nom. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, ___ U.S. ___, 115 S. Ct. 1671 (1995), in which three New York State surcharges imposed on hospital bills of varying amounts of 9%, 11%, and 13%, depending on the identity of the third-party payor, were invalidated by the Second Circuit as ERISA-preempted (22a).

On June 23, 1994, the Second Circuit reversed the district court. The court rejected the district court's conclusion that the HFA was a law of general applicability. The court stated that because "the HFA targets only the health care industry" which is, "by definition, the realm where ERISA welfare plans must operate, [the assessment] was bound to affect them" (12a). Because the Fund had chosen to provide medical benefits through its own medical centers, the court concluded that the HFA operated as an immediate tax on payments and contributions which were intended to pay for medical benefits (JA 16).

Relying on its decision in *The Travelers Insurance Co. v. Cuomo*, 14 F.3d 708 (2d Cir. 1993), *rev'd sub nom. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, ___ U.S. ___, 115 S. Ct. 1671 (1995), the Second Circuit held that the assessment "relates to" the Fund directly by reducing assets otherwise available to provide health care benefits, thereby causing the Fund to reduce benefits provided or charge more to its beneficiaries (JA 16-17). According to the court, the impact of the assessment "will detrimentally affect the central mission and purpose of the Fund and hence cannot be characterized as remote and tenuous" (JA 16). Addressing the Fund's statement that it could avoid the tax altogether by funnelling all medical center income through the Fund, the court held that "such a restructuring would alter the Fund's established method of administration" and would in itself be a basis for ERISA preemption (JA 17).

[3] The district court did not reach the other issues raised by the State, namely that the Tax Injunction Act, 28 U.S.C. § 1341 (1994), barred the complaint and that the claim for a refund is barred by the Eleventh Amendment to the United States Constitution.

The State filed a petition for a writ of certiorari on October 21, 1994, after this Court granted the State's request for an extension of time within which to file the petition (26a). On May 1, 1995, this Court granted the petition, vacated the judgment, and remanded the case for further consideration in light of its decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, ___ U.S. ___, 115 S. Ct. 1671 (1995) ("*Travelers*") (5a).

On January 4, 1996, the Second Circuit issued a decision adhering to its initial determination that the HFA was preempted by ERISA insofar as it applies to the income of a medical center owned by an ERISA fund. The court noted that in *Travelers*, the impact of the surcharges on ERISA plans was indirect because the surcharges were imposed not on "ERISA plans themselves, but on insurance carriers providing health insurance coverage to plans and their beneficiaries" (JA 8). The court held that this Court's decision in *Travelers* did not control because, unlike *Travelers*, "there is no third party between the plan and the tax imposed pursuant to the HFA," and the statute therefore "depletes the Fund's assets directly" (JA 9). The court concluded that "[n]othing in *Travelers* undermines our reliance on the HFA's direct economic

impact upon the Fund as a basis for finding ERISA pre-emption nor precludes a determination that a state law's direct economic impact on ERISA plans is sufficient for a finding of pre-emption" (JA 9).

SUMMARY OF ARGUMENT

The HFA is a tax of general applicability imposed upon providers of hospital care. Whether characterized as direct or indirect, its effect on a plan's cost of doing business neither dictates nor restricts plan benefit structures nor plan administration. It, therefore, does not relate to a plan even when imposed upon plan-owned medical centers.

In *Travelers*, 115 S. Ct. at 1679, this Court held that state laws of general applicability in areas of traditional state regulation do not relate to plans, even if they have an economic impact upon plan choices, so long as they do not dictate or restrict plan benefit structure or plan administration. In *Travelers*, the Court held that the surcharges were not preempted, even though they affected the cost of benefits and the relative costs of competing insurance to provide them, because they did not bind plan choice. The HFA, even as applied to plan-owned medical centers, does no more. The HFA affects the cost of medical care and plans must use additional assets to cover the increased costs. This type of economic impact upon plans does not, however, relate to plans.

Travelers involved hospital surcharges on medical bills paid by insurers and HMOs which indirectly increased plan costs. The HFA, in this case, is imposed "directly" upon plan-owned medical centers. That difference is not a legally significant distinction. This Court has never relied upon the directness or indirectness of a law's impact upon plans as a determinative factor in preemption analysis. Thus, in *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988), this Court held a garnishment law of general applicability did not relate to plans, despite its direct imposition of

legal obligations upon plans. On the other hand, laws do not escape preemption simply because they bear indirectly upon plans. *Ingersoll-Rand v. McClendon*, 498 U.S. 133 (1990). Instead, this Court has examined the nature of the impact upon plans in determining whether a law relates to plans.

The HFA is also not preempted as applied to plan-owned medical centers because operation of a medical facility is not a plan function which ERISA preemption was designed to protect. Employee benefit plans operate and are subject to state laws in many capacities other than as plans. They are employers, property owners, purchasers of goods and services and in some cases providers of medical care, day care and prepaid legal services. States may regulate plans as they engage in these activities so long as that regulation does not mandate or restrict the plan functions ERISA preemption was designed to protect.

ERISA preemption protects the plan functions of plan administration and benefit structure. The operation of a medical center is not one of these plan functions protected by ERISA preemption. It does not involve the type of plan administrative activities that this Court identified in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987). The Fund's ownership of the medical centers is not a plan benefit structure. The benefit provided by the plan is health care coverage. The benefit has been structured to provide coverage only for the health services available at certain centers. However, ownership of the medical centers is irrelevant to the benefit's structure. Both the NYSA plan, and another unrelated plan, the PPGU plan, have been similarily structured to limit coverage to the medical centers owned by the NYSA Fund. That one Fund owns the centers and the other does not, is incidental to the benefit structure of both plans.

The State is not precluded, in any event, from regulating the centers. Regulation of the plan-owned centers relates, at most, to the benefit provided by the plan, not the plan itself.

In *Fort Halifax*, 482 U.S. at 11, this Court held that laws that related to benefits, but not to plans, were not preempted by ERISA. While that case involved regulation of a benefit where no plan was involved, the Court's reasoning applies equally where a benefit is provided by a plan. States may regulate benefits so long as that regulation does not impermissibly intrude upon the structure or administration of the plan that provides the benefit.

ARGUMENT

THE HEALTH FACILITY ASSESSMENT DOES NOT "RELATE TO" ERISA PLANS BECAUSE IT IS A LAW OF GENERAL APPLICABILITY WHICH DOES NOT DIRECTLY OR INDIRECTLY MANDATE AN EMPLOYEE BENEFIT PLAN'S STRUCTURE OR ADMINISTRATION

Congress enacted ERISA as a "comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983). However, ERISA's protection of participants in employee benefit plans extends only to the administration of plans. ERISA does not require the provision of benefits, nor does it substantively regulate any of the benefits which may be provided by plans. *Travelers*, 115 S. Ct. at 1674.

ERISA preempts laws that "relate to any employee benefit plan." 29 U.S.C. § 1144(a). While this preemption provision is broad, it does not alter the basic presumption in any preemption analysis that Congress does not intend to supplant state law. *See Maryland v. Louisiana*, 451 U.S. 725, 746 (1981). Moreover, where a State is acting in a field of traditional state regulation, "the historical police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest intent of Congress." *Travelers*, 115 S. Ct. at 1676 (citing *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

Whether characterized as direct or indirect, the economic impact of a law of general applicability that does not control plan administration or benefit structure is irrelevant to preemption analysis. The HFA is a provider tax of general applicability designed to achieve a policy objective in an area of traditional state regulation, health care.[4] The law's effect on

[4] At least twenty other States utilize similar kinds of provider taxes to finance health care initiatives. *See* Ala. Code § 40-26B-21 (1995) (imposing "providers of medical services privilege tax" on nursing facilities); Conn. Gen. Stat. § 12-263(b), as amended by Pub. Act 96-144 (West, WESTLAW through 1996 Reg. Sess.) (tax on "hospital gross earnings of each hospital"); Fla. Stat. Ann. § 395.7015 (West 1995) (imposing 1.5% assessment on annual net operating revenues of certain "health care entities"); Haw. Rev. Stat. § 346E-2 (1995) (taxes of 6% and 4% imposed on "nursing facility income" and "hospital income" respectively); Ill. Ann. Stat. § 5/5A-2 (Smith-Hurd 1993 & Supp. 1995) (assessment of 1.88% of "adjusted gross hospital revenue" of "each hospital provider"); Ky. Rev. Stat. Ann. § 142.303 (Banks-Baldwin 1995) (2.5% tax on gross revenues of providers "for the provision of hospital services"); Me. Rev. Stat. Ann. tit. 22, § 391 (West 1992 & Supp. 1995) (assessment of .15% of hospital's "gross patient service revenues"); Mass. Ann. Laws ch. 118 F, § 15 (Law. Co-op. 1994 & Supp. 1996) (hospital assessments); Minn. Stat. § 256.9657 (West, WESTLAW through 1996 Reg. Sess.) (assessment on hospital revenues, nursing home beds and HMOs); Miss. Code Ann. § 43-13-145 (WESTLAW through 1995 Reg. Sess.) (assessment on nursing homes of two dollars per bed per day); Mo. Rev. Stat. § 208.453 (West, WESTLAW through 1995 1st Reg. Sess.) (hospitals pay "federal reimbursement allowance for the privilege of engaging in the business of providing inpatient health care"); Mont. Code Ann. § 15-60-102 (1995) ($2.80 "utilization fee" paid by each "nursing facility" for "each bed day in the facility"); N.H. Rev. Stat. Ann. § 84-A:2 (1991 & Supp. 1995) (tax "at a rate to be established by the legislature each biennium upon the gross patient services revenue of every hospital"); R.I. Gen. Laws § 44-51-3 (Michie, WESTLAW through 1995 Reg. Sess.) (assessment of 3.75% on "gross patient revenue received by every nursing facility"); S.C. Code Ann. § 12-23-810 (Law. Co-op. Supp. 1995) (hospital tax based on total expenditures of each hospital as a percentage of total hospital expenditures state-wide); Tenn. Code Ann. § 68-11-216(d) (WESTLAW through 1996 2d Reg. Sess.) (annual nursing

a plan's cost of doing business, whether characterized as direct or indirect, neither restricts nor dictates plan benefit structure or plan administration. With only a "tenuous, remote or peripheral connection" to plans, the HFA does not relate to plans so as to trigger preemption. *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 130 n.1 (1992) (citing *Shaw*, 463 U.S. at 100 n.21).

A. The HFA Does Not Relate to Plans Because It Has Only an Economic Impact upon Plans Which Does Not Restrict Plan Choice

In *Travelers*, this Court recognized that it was required to "go beyond the unhelpful text" of ERISA's preemption provision and "look instead to the objectives of the ERISA statute as a guide to the scope of state law that Congress understood would survive." 115 S. Ct. at 1677. Construing ERISA's preemption provision in light of its objective, "to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans," 115 S. Ct. at 1677-78, this Court held that state laws relate to plans and are preempted when they mandate "employee benefit structures or their administration." 115 S. Ct. at 1678.

This Court found that the challenged surcharges in *Travelers*, which made Blue Cross a more attractive insurance alternative, only had "an indirect economic effect on choices made by insurance buyers, including ERISA plans." 115 S. Ct. at 1679. Such economic influence "does not bind plan administrators to any particular choice and thus function as a

home tax); Utah Code Ann. § 26-36-105 (1995) (Medicaid Hospital Provider Temporary Assessment imposed on hospitals "audited gross patient revenues"); Vt. Stat. Ann. tit. 33, §§ 1950-58 (Supp. 1996) (4.02% "hospital assessment" imposed on each hospital's "audited gross inpatient revenues"); W. Va. Code §§ 11-27-9, 11-27-15 (1995) (health care providers tax of 2.5% of gross receipts on providers of "inpatient hospital services" and "outpatient hospital services"); Wis. Stat. § 50.14 (West Supp. 1995) (assessment on "occupied, licensed beds" of nursing home facilities).

regulation of the ERISA plan itself." 115 S. Ct. at 1679. ERISA therefore does not preempt state laws that have an impact "on the costs of benefits and the relative costs of competing insurance to provide them" so long as they do not otherwise preclude uniform administration of plans on an interstate basis. 115 S. Ct. at 1679. This Court also noted that "nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." 115 S. Ct. at 1680.

The reasoning of *Travelers* does not yield a different result in this case simply because the tax is applied to a hospital that an ERISA plan chooses to own and operate. The HFA is imposed upon all "hospitals" regardless of a hospital's relationship to ERISA plans. Like the surcharges at issue in *Travelers*, the HFA is a generally applicable statute that operates in an area of traditional state regulation. The HFA is neither specifically designed to apply to ERISA plans nor does it refer to ERISA plans. *See Greater Washington Board of Trade*, 506 U.S. at 130. Indeed, it "functions irrespective of the existence of an ERISA plan." *Ingersoll-Rand*, 498 U.S. at 139.

In *Travelers*, this Court's principal concern was whether the economic impact of the surcharges upon plans mandated a particular plan benefit structure or plan administration. In *Travelers*, this Court held that the surcharges were not preempted even though they affected the cost of benefits and the relative costs of competing insurance to provide them. The HFA, as it is applied to ERISA plan-owned medical centers, does no more than the surcharges in *Travelers*; it affects the costs of benefits.

In this case, only the preemption of the tax would have an economic impact on plan choices. Since the tax is imposed on all hospitals in New York, plans which do not own medical centers pay the tax as a portion of the charges they pay for

medical services delivered by other hospitals. If preempted, plans which own hospitals will be able to avoid the HFA and then operate at less expense.

Like the surcharges at issue in *Travelers*, the HFA increases the cost of hospital care throughout the State. The increased costs created by both laws are ultimately borne by plans which must use additional plan assets to cover the costs. Yet, this Court in *Travelers* held that this type of economic impact is not sufficiently related to plans to trigger preemption. 115 S. Ct. at 1679, 1681.

B. The Second Circuit Erred in Basing Its Analysis on the Directness, Rather Than the Nature, of a Law's Impact Upon Plans

The Second Circuit's decision on remand rests solely on the court's characterization of the HFA as having a "direct" impact upon the Fund. In the court's view, the impact of the HFA is direct because "there is no third party between the plan and the tax" (JA 9). This Court has never based its preemption analysis upon whether a law affects plans directly or through the regulation of another entity.

Nothing in *Travelers* supports the conclusion that a law which increases costs to plans "indirectly" through its application to third parties, such as that held not to be preempted in *Travelers*, is transformed into a preempted law when applied to a plan that happens to own or operate the third party. Indeed, the HFA is very similar to the 9% assessment upheld in *Travelers*, which is imposed upon the in-patient hospital costs paid by health maintenance organizations ("HMOs"). Under the Second Circuit's rationale, the 9% would be preempted if an HMO was owned by an ERISA plan. None of the reasons articulated by this Court for finding that the 9% assessment is not preempted is affected merely because a plan chooses to own an HMO, instead of purchasing HMO memberships.

Nor has this Court ever construed ERISA as preempting all laws that "directly" operate upon plans. In *Mackey*, the Court upheld a Georgia garnishment statute that operated directly upon plans. There was no third party between the law's obligations and the plan. Yet, this Court held that the administrative burdens and costs resulting from the direct application of the statute to plans were not enough to trigger preemption. 486 U.S. at 831. In *Mackey*, this Court also noted that run-of-the-mill state lawsuits against ERISA plans for unpaid rent, failure to pay creditors, and torts committed by plans were not preempted by ERISA. 486 U.S. at 833. The legal obligations at issue in such lawsuits also are felt directly by ERISA plans. On the other hand, this Court has held that laws do not escape preemption simply because they affect plans indirectly through another entity. *Ingersoll-Rand*, 498 U.S. at 139 (laws which depend upon the existence of ERISA plans are preempted even though their effect upon plans is indirect).

This Court instead has examined the nature of the law's effect upon the plan in determining whether the law relates to the plan. In *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981) and *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), the laws at issue were applied directly to plans. They dictated plan structure, therefore they related to the plans. In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985), this Court found that the mandated benefit law at issue "bears indirectly" on plans since it regulated the content of insurance policies which are sold by insurance companies to plans. Nevertheless, since it dictated plan benefit structure by requiring mental health coverage, the law related to plans. In *Travelers*, the impact of the surcharges was similarly indirect inasmuch as the law regulated hospitals and not plans. However, this Court held that the law imposing those surcharges was not preempted, since the law did not bind plan choices. Thus, whether a law's impact upon ERISA plans is labeled direct or indirect is not a legally determinative distinction.

C. The HFA Is Not Preempted Because It Is Imposed upon the Fund In Its Capacity as a Provider of Medical Services, Not as a Plan

The HFA is not preempted for the additional reason that the operation of a medical center is not a plan function that ERISA preemption was designed to protect. The Fund pays the HFA as part of its operation of the medical centers. The Fund operates the medical centers not as a plan, but as a provider of medical services. The State may regulate this activity so long as the regulation does not mandate or restrict the plan functions, administration, and benefit structures, which ERISA preemption was designed to protect.

The NYSA plan provides the benefit of health care coverage. This benefit is structured to cover services provided at particular medical centers. Regulation of the centers, as hospitals, does not mandate or restrict the plan's choice of that benefit structure. It therefore cannot be said to relate to the plan. Even if the benefit is defined as the provision of medical services as opposed to health care coverage, preemption is not implicated. States may regulate employee benefits provided in-kind so long as that regulation does not mandate or restrict a plan's administration, or the structure of the benefits it provides. Therefore, a state tax on hospital income does not relate to a plan even when the entity that operates the hospital also administers an ERISA plan whose participants receive medical services at the hospital.

1. ERISA preemption only protects the plan functions of plan administration and benefit structure and does not extend to other activities in which plans engage

The purpose of ERISA preemption is to permit "nationally uniform administration of employee benefit plans." *Travelers*, 115 S. Ct. at 1678; *see also FMC Corp.*, 498 U.S. at 59-60; *Ingersoll-Rand*, 498 U.S. at 142; *Fort Halifax*, 482 U.S. at 10;

Shaw, 463 U.S. at 105. Accordingly, state laws that mandate plan benefit structures or plan administration relate to plans. *Travelers*, 115 S. Ct. at 1679. However, the provision of medical services is not within the scope of these plan functions which ERISA preemption is designed to protect, even when the services are provided by a plan-owned facility.

This Court has held that state laws that require plans to structure themselves in a certain manner relate to plans. Thus, in *Alessi*, 451 U.S. 524-25, a state law that prohibited plans from using a particular method to calculate pension benefits related to plans. In *FMC Corp.*, 498 U.S. at 60, an anti-subrogation statute, which prevented plans from being structured so as to require reimbursement from a third party in the event of recovery, related to plans. In *Metropolitan Life*, 471 U.S. at 735, and *Shaw*, 463 U.S. at 96, laws that would require plans to structure themselves to provide certain benefits, mental health coverage and pregnancy disability respectively, were held to relate to plans.

In *Fort Halifax*, 428 U.S. 1, 9, this Court discussed the scope of plan administrative practices that Congress intended to protect in enacting section 514(a):

> An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits.

Thus, ERISA protects from state regulation the administrative practices in which plans must engage in order to pro-

vide benefits. However, not every activity in which a plan engages has that purpose and is protected by ERISA pre-emption. For example, in *Mackey*, 486 U.S. at 834, this Court held that the burden of the administrative practices necessarily engaged in by plans in order to comply with a general garnishment law did not trigger preemption.

Plans engage in many activities that are not plan functions. Plans purchase supplies, own or lease property, enter into contracts with banks, accountants, and attorneys, and act as employers of their own employees. Since ERISA does not preempt state laws that do not relate to plan functions, States may require plans to pay real estate, sales, and unemployment taxes and may require plans to comply with state contract and employment law. Similarily, the "run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan," *Mackey*, 486 U.S. at 834, do not relate to plans because they do not affect a plan in its capacity as a plan. When plans engage in non-plan activities, they may be regulated by the State to the same extent as any other commercial entity.

The distinction between plan functions and plans acting in other capacities is reflected in the statute and in this Court's decisions. ERISA explicitly allows a single entity to perform plan and non-plan functions. It permits, for example, employers to act both as plan sponsors, free from ERISA's fiduciary duties, and plan administrators, subject to them. *See* 29 U.S.C. § 1108(c)(3). ERISA also provides, as this Court has recognized, that any entity, whether an employer or not, that performs plan and non-plan administration functions is subject to ERISA only when it performs plan functions. *See* 29 U.S.C. § 1002(21)(A) (a person is an ERISA fiduciary only to the extent that he or she exercises any discretionary authority over plan administration or plan assets). Thus, in *Curtiss-Wright Corp. v. Schoonejongen*, ____ U.S. ____, 115 S. Ct. 1223, 1228 (1995), this Court noted that an employer who is also a plan administrator is not subject to ERISA's fiduciary

duties when adopting, amending or terminating a plan because these are not acts of plan administration.[5] In *Varity Corp v. Howe*, ____ U.S. ____, 116 S. Ct. 1065, 1071 (1996), in order to determine if fiduciary duties were implicated, this Court was required to determine whether a corporate employer was acting in its capacity as a plan administrator or in its capacity as an employer when it made certain misrepresentations to its employees. While *Varity* and *Curtiss-Wright* concerned an employer who also administers a plan, the need to distinguish plan activities from non-plan activities is equally present where, as in this case, a trust fund has been set up to administer a plan.

2. Plan operation of a hospital does not implicate plan administration

In this case, preemption analysis focuses on the distinction between plan functions and other activities in which a plan may engage. The Fund must perform certain administrative functions in order for the plan to operate. Those include determining participant eligibility, determining eligibility to be treated at a particular facility,[6] determining the amount and monitoring the availability of funds necessary to operate the facilities, determining how the funds will be made available to the facilities, assuring the availability of these funds, sending required notices, and keeping necessary records. These are the type of plan administrative functions which ERISA preemption protects from state regulation.

The Fund also acts in other, non-plan capacities. Although these other functions are performed by the Fund they are separate and distinct from the plan functions that ERISA pre-

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[5] Although a plan sponsor is not subject to ERISA's fiduciary duties when it acts to create, amend, or terminate a plan, those are plan benefit structure decisions, state regulation of which will relate to plans.

[6] Certain participants are eligible to be treated at only one of the medical centers (JA 78).

emption is designed to protect. Inasmuch as the Fund operates the medical facilities, it must also, *inter alia*, obtain the necessary licenses, purchase and maintain necessary medical equipment, hire necessary personnel, assure the proper credentialing of the medical personnel, comply with the State's quality control standards, devise and implement procedures for disposing of medical waste and for regular maintenance and sterilization of medical equipment and pay the tax at issue in this case. When the Fund operates in its capacity as a provider of medical services, it is subject to state laws that regulate such providers. The Fund also operates as an employer and, as such, is subject to state regulation of employers. Indeed, in *Shaw*, this Court recognized that while state anti-discrimination laws were preempted as applied to plans when they required plans to pay specific benefits, they were unaffected insofar as they prohibited discrimination in hiring, firing and promotion. 463 U.S. at 98 n.17.

In addition to operating medical facilities, plans may provide in-house day care centers. In that case, state laws that impose licensing fees or regulate staffing requirements, safety requirements, and sanitary requirements for day care centers are imposed directly upon plan operated centers. However, these requirements are imposed upon a plan as a day care provider and do not relate to the administration of the plan. Moreover, procedures designed to comply with these requirements are not the type of claims processing procedures which ERISA preemption is designed to protect. The same is true of prepaid legal services plans. ERISA may preempt the regulation of prepaid legal services plans *qua* plans, but does not reach the regulation of lawyers who render legal services under the plans.[7]

[7] As noted by the New York Court of Appeals soon after ERISA was passed, the State's interest in regulating prepaid legal services plans is to "assess the authenticity of the plan, to assure its freedom from any taint of improper professional conduct, to preserve the attorney-client relation, to require full disclosure to prevent fraud or other wrong upon the public, and, above all, to make sure that future professional conduct on behalf of the applicant organizations remains subject to the disciplinary control of the Appellate Division." *Matter of Feinstein (Attorney General)*, 36 N.Y.2d 199, 205, 326 N.E.2d 288, 291 (1976).

The distinction between plan functions and other activities in which plans engage is also important because it is increasingly common for plan sponsors to contract with managed care organizations such as HMOs which function as providers of care, in addition to providing many plan administrative functions. Self-insured plans may engage third parties to administer plans. As a result, these third parties may engage in plan activities such as processing claims and making benefit determinations. However, they also are themselves business enterprises. A State must be able to regulate the non-plan related activities in which these businesses engage. *See Metropolitan Life*, 471 U.S. at 741 (the regulation of an insurer or the way it sells insurance does not relate to plans, even though regulation of the contents of the insurance policy sold by insurers to plans relates to them since it mandates plans' benefit structures).

3. State regulation of a fund-owned hospital does not implicate plan benefit structures

In this case, the HFA is imposed upon the Fund in its capacity as a provider of medical care. Coverage for hospital care is one of the benefits which ERISA contemplates that plans may provide "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1). Even so, the State may regulate ERISA plan-owned hospitals because the ownership of the hospital is not part of the plan's benefit structure.

The benefit provided by the NYSA plan in this case is health care coverage. The plan assumes the obligation for the payment of certain health care services that are provided to plan participants. This benefit, health care coverage, is the same regardless of whether a plan provides it by self-insuring, purchasing HMO memberships, purchasing traditional indem-

nity insurance, or providing services in-kind. The NYSA plan's benefit has been structured to provide coverage only for the health care services available at certain medical centers. The decision to limit health care coverage to particular facilities is a benefit structure decision. It is similar to the decision, for example, to exclude from coverage mental health services, or to limit coverage to medical services arranged through certain HMOs. State regulation of that type of benefit structure decision relates to plans. *See Metropolitan Life*, 471 U.S. at 739.

However, the fact that the NYSA Fund happens to own the centers is incidental to the plan's benefit structure. Both the NYSA plan and another unrelated plan, the PPGU plan, are similarly structured to provide coverage for the services available at the same medical centers. The PPGU plan does not own the centers, and the NYSA Fund does. Nonetheless, each has the same benefit structure. State regulation does not affect the NYSA plan any differently than it does the PPGU plan, although the NYSA Fund happens to own the centers. In both cases, state hospital regulation affects the cost of operating the centers which, in turn, affects the cost of the coverage.

Traditional state regulation of the medical centers does not affect the plan's ability to structure its benefit uniformly across state lines. The NYSA Fund operates medical centers in both New York and New Jersey. Differing state regulation of hospitals may require the Fund, as a medical services provider, to administer its hospitals somewhat differently. However, the ability of the plan to structure its benefit by limiting coverage to certain medical centers is not affected.

4. A State may regulate an employee benefit to the extent that such regulation does not relate to a plan

The State is not precluded, in any event, from regulating the centers as hospitals. Regulation of the fund-owned medical centers relates, at most, to the benefit provided by the plan, not to the plan itself.

Most ERISA benefits are strictly financial. The plan pays money to a participant or a beneficiary in the event of some contingency such as retirement or death. A few welfare benefits, such as health care coverage, involve payment for services. ERISA contemplates that plans may provide coverage of certain welfare benefits by delivering services in-kind. Thus, plans may operate medical centers, day care centers, and prepaid legal plans, instead of providing coverage by paying for services rendered by others. *See* 29 U.S.C. § 1002(1). The decision to deliver certain services in-kind, however, does not transform the benefit provided by the plan into the plan to provide the benefit.

ERISA defines a welfare benefit plan as follows:

> any plan, fund, or program which was heretofore . . . established . . . to the extent that such plan, fund, or program was established . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services . . . .

29 U.S.C. § 1002(1).

The structure of the statute indicates that the benefits provided by plans are distinct from the plan to provide them. A "plan, fund, or program" is "established or maintained for the

purpose of providing" the specified benefits. Benefits, in turn, are what plans provide. Moreover, throughout ERISA the words "plan" and "benefit" are used separately and are not treated as equivalents. *Fort Halifax*, 482 U.S. at 8.

ERISA neither requires the provision of benefits nor establishes any minimum participation, vesting, or funding requirements for welfare benefits. Instead, "[i]n enacting ERISA, Congress's primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds." *Massachusetts v. Morash*, 490 U.S. 107, 115 (1989). ERISA seeks to assure that an employee's expectation of benefits is not defeated by poor plan administration. *Id.* at 112. Thus, ERISA is concerned with the administrative structure established to provide the benefits, not the benefits themselves.

In *Fort Halifax*, 482 U.S. at 7, this Court relied on this distinction between "benefits" which an employer may provide and an "employee benefit plan" in holding that a Maine statute which required employers to make a one-time severance payment in the event of a plant closing, was not preempted. While the law mandated an employee benefit, it did not relate to a plan because compliance with the law did not require the on-going administrative practices which define a plan. Thus, this Court held that laws that relate to benefits, but not to plans, are not preempted by ERISA. *Id.* at 11. While *Fort Halifax* involved the regulation of a benefit where no plan was involved, the Court's reasoning applies equally to situations where the benefit is provided by a plan. Therefore, a State may regulate one of the benefits enumerated in ERISA even when a benefit is provided through a plan, so long as the regulation of the benefit does not impermissibly intrude upon the structure or the administration of the plan that provides benefits.

In fact, while ERISA's legislative history addressing the scope of preemption is limited, it contains guidance on pre-

cisely this issue. Senator Javits, a sponsor of ERISA, explained that while ERISA would preempt the "form and content" of a prepaid legal service plan, it would *not* preempt state regulation of the attorneys who provide the legal services. 3 Subcommittee on Labor of the Committee on Labor and Public Welfare, 93d Cong., 2d Sess., Legislative History of the Employee Retirement Income Security Act of 1974, at 4789-90 (Comm. Print 1976).

States have traditionally regulated medical care, day care, legal services and apprenticeship, the types of benefits that ERISA contemplates plans may provide by delivering services in-kind. Whether it is the tax in this case or more substantive regulation, such as quality control standards, the only impact that state regulation of these benefits has on plans is possibly to increase the cost of structuring the benefit as delivery of in-kind services. This economic effect is insufficient to result in preemption. *Travelers*, 115 S. Ct. at 1683.

CONCLUSION

For the reasons set forth, the Court should reverse the judgment below.

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